Financial Policy

Thank you for choosing Southwest Orthopaedic Group for your health care needs. We are committed to providing you with quality health care. The purpose of this financial policy is to advise you of your responsibility for services rendered. If you have any questions regarding this policy please let us know before signing.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at time of visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This agreement is part of your contract with your insurance company.
3. **Non-covered services**. Please be aware that some or all services you may receive may be non-covered services or not considered reasonable or necessary by insurer. You are responsible for payment of these services in full at time of visit.
4. **Proof of identification and insurance.** All patients must complete our patient information form prior to seeing the physician. We must obtain a copy an identification card (i.e. driver's license) and current valid proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission**. We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. You are responsible for any remaining balances after your insurance processes your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you change coverage it is your responsibility to inform us of coverage changes.
7. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from this practice. If this is to occur, you may be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis only.
8. **Overpayments and Underpayments** Overpayments received from you will be applied to any outstanding balances on your account.
9. **Missed appointments**. Our policy is to charge for missed appointment not canceled within a reasonable amount of time (at least within 24 hours). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
10. **Returned Checks** Our office charges a $25 fee for returned checks.
11. **Billing Information** If you have any questions regarding your account please contact our billing department at 512-451-5221. Please note our billing services are in Arizona and you may receive correspondence from PO Box 52194 Phoenix, AZ 85072 on our behalf.

I have read and understand the payment policy and agree to abide by its guidelines. In additional, I hereby give Southwest Orthopaedic Group the authority to check my credit when making payment arrangements with Southwest Orthopaedic Group and/or its contracted credit agency.

Patient Name_____ Acct#_____

Signature_____ Date: _____